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# WELFARE in REVIEW

July–August 1970
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**The Utilization of Psychological Knowledge in Rehabilitation**

**Rural Home Repair in Eastern Kentucky A Local-State-Federal Demonstration**

**How Employable Are AFDC Women?**

U.S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND WELFARE

Social
and
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Service

# WELFARE in REVIEW

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JULY-AUGUST 1970

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# The Utilization of Psychological Knowledge in Rehabilitation

Tamara Dembo

Handicapped people, representatives of different professions, and laymen all believe that psychological problems are involved in rehabilitation. Expectations are widespread that psychology offers solutions to such problems. Yet, in actuality, scientific psychological knowledge is rarely usable in rehabilitation. The failure to apply such knowledge is frequently ascribed to the difficulty of putting theoretical knowledge into practice, to matching concepts to concrete contents and specific cases. The major issue of this article is that the difficulty lies not in "translation" but elsewhere.

**The actuality**

Before we can use research findings in everyday life, we will have to do more than direct ourselves to methods of applying abstract knowledge to concrete situations—we will also have to place considerable effort into acquiring relevant knowledge. Though such knowledge is available in psychology to some extent, psychologists disregard whole aspects of concern relevant to everyday life and frequently reject them on the grounds that they are "not scientific," that is, they cannot be studied objectively.

In raising the question of the relevance of our scientific knowledge to life problems, we must first consider whether the word *problem* means the same in science as in everyday life. Actually it does not. In science *problem* means a content worthy of investigation; in everyday life *problem* means trouble needing alleviation. Both kinds of problems are worthy of concern but on very different grounds: the scientific *problem* on the grounds of theoretical importance, the life *problem* as entailing human suffering to be overcome. The scientific problem evolved from theoretical considerations might be of little pertinence to the everyday problems of people, and vice versa. But *problem* is not the only term with different meanings in scientific psychology and life. Even *to be concerned* has different meanings. The scientist concerns himself with a scientifically interesting or valuable problem; in life to be concerned means being worried about and trying to overcome a problem. Also, solving a problem means something different in both cases: in the first—placing within a theoretical framework, in the second—finding a remedy.

I strongly believe that to arrive at knowledge relevant to life, instead of selecting scientific topics for their theoretical importance, we must deal theoretically with problems of concern to people in everyday life. If life problems do not fit existing psychological theories—too bad for the existing theories—a new theory will have to be developed. At the very inception of research, in selecting a problem, the merger needed between the scientific quest and life problems has to take place. The use of scientific knowledge requires the introduction of life problems at the very start of psychological investigations.

The necessary connection of scientific work with life is not fulfilled by an appropriate initial choice of a problem—it requires a permanent liaison between the scientific endeavor and life, an interrelating of the two throughout the investigation. It is necessary to consider how the investigation should be approached, which data should be taken into account, how they should be analyzed, how to arrive at novel conceptualizations, and

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what kind of principles and conclusions should be drawn.

To have a psychology permitting application, a psychology able to alleviate everyday problems, basic scientific beliefs, assumptions, and evaluations will have to be reconsidered. Only then will psychology become more useful.

Among the most severe changes needed is that of introducing two viewpoints instead of one concerning investigation. Traditionally, psychology investigates matters from the standpoint of the investigator, deals with what he considers important and what he selects. Rehabilitation psychologists need to add to the investigator's view the view of the subject, that is, the client or sufferer. Traditional psychologists do not deny that the subject-sufferer's view may be different from their own, but they do not think that in selecting and dealing with the problem of investigation the sufferer's view is important and should be taken into account. Those psychologists who believe that *theory* is their only guide in selecting and dealing with problems and that *behavioral observations* are the only method of acquiring valid data expect the subject to "be seen but not heard." They believe that the governance of the investigation is the matter of the investigator alone and should be left to him. The person whose problem is investigated should not take part in the investigation—he is just a subject not a coworker.

However, in everyday life a very appropriate question is asked: Whose problem should be alleviated, the investigator's or the sufferer's? Who really knows how it hurts, when it hurts more, or when it starts to hurt less? Of course, it could be argued that theories are the realm of the learned man. But to know how it feels, a man does not have to be learned. In its vivid fullness, directly and in an unadulterated way, hurting is accessible to observation as an experience only to the sufferer. His view of what brings up suffering and lessens it is important, and his view might be different from that of the best outside observer.

In suggesting that the choice of a problem for investigation should be based on its importance in everyday life and not on its pertinence to preconceived theoretical development, I am not only suggesting that the unilateral reign of the goddess of science, Theory, be terminated but also that the investigator be asked to give up his position as the only determiner of scientific procedures. This will not be easy for some. But where the alleviation of suffering is intended, differences in the views of the investigator and the sufferer have to be studied. The investigator and the sufferer together have to perform these tasks: determine the problem for investigation; investigate it; judge whether attempts at alleviation have been successful; and, most important, insure that the sufferer's view has been taken into account by the investigator in his choice of methods and procedures. The need for this basic change will become clearer as we go further.

### The differences in views

Of course, it is not enough to point out that the views and judgments of the investigator and the sufferer differ. The differences must be specified. This I will attempt to do.

First of all, the sufferer and the observer differ in the way they are *connected* with the problem: one is afflicted with the problem, the other perceives the problem as that of another person, that is, from the outside. In other words, the sufferer is in direct contact with the problem, wrapped up in it. It is what he experiences; it is *his* problem. The investigator-observer, however, perceives the problem from a distance, that is, he can reach it only indirectly through another person's reaction to the problem. The direct connection of the sufferer with the problem means that his psychological makeup, or personality, and his situation will influence his perception of the problem and his way of dealing with it. In the case of the observer, in addition to determinants expressed in the reaction of the sufferer, his personal views and his situation will determine his view of, his dealing with, and his judgments concerning the sufferer's matters. Expressed conceptually, the observer is the outsider to the person observed and to his suffering. The sufferer, enwrapped in his problem, is the insider. This description is in quasi-spatial psychological terms; it defines the psychological *position* of the sufferer and observer in regard to suffering.

The position of the insider and the outsider is of importance not only in rehabilitation psychology but also in psychology as a whole. Generally, in the social-relations space, the particular position of the carrier of a problem, or of the observer of the carrier, is an essential determinant of their views. It is to be taken into account in a great number of interpersonal relations such as those of the observer and the observed, the investigator and the investigated (whether investigated scientifically or otherwise), the interrogator and the interrogated, the examiner and the examined (for example, when a student is examined by a teacher or a patient by a physician).

It is the difference in the distance from a problem that produces *discrepancies* in viewing the problem. As a

concrete example, take the attitudes of the insider and the outsider as to the urgency of relieving pain. The sufferer wants to be helped and helped *now*. He is hardly interested in the profits that may accrue to the next generation, if a choice between helping him or helping humanity has to be made. The investigator thinks of benefiting humanity. The sacrifice of "only one person" is made easier through his distance from the person's suffering. Also, the views of "facts" are different: the sufferer will see the slightest change as an indication of progress, the professional person will see it within the entire process of rehabilitation as a minor change.

**Two psychologies**

Neither the sufferer nor the observer is correct or right in his opinions, recommendations, and observations. Only by introducing superordinate principles stemming from a set of values (those of a particular person or a professional code) can we judge who is right or wrong. When such principles are lacking, we can only say this: whether you believe you are correct in your statements depends on your position and, therefore, which viewpoint presents itself to you.

In taking seriously the viewpoint not only of the observer but also of the sufferer, one comes to the radical conclusion that there are two psychologies: namely, the psychology of the observer and the psychology of the sufferer. Faced by the two, we have to take a stand whether to deal with one or with both. This demand leads to another question: Under what conditions in everyday life or in science will we, and perhaps should we, lean in our views, decisions, and conclusions—toward the psychology of the observer or that of the sufferer, or can we (and how can we) take both into account?

Arguments for the special importance of one or the other viewpoint are many. The sufferer can argue his case thus: he is the person who needs help and he cannot wait until remote, theoretical problems are solved; being closest to the problem—he knows it best; and he has to judge what is helpful to him. The researcher could argue for his viewpoint this way: the observer is objective, not emotional, and, therefore, closer to the truth of the matter; he is concerned with stating facts and checks the certainty of his statements; as a trained person he has more knowledge; he knows more cases and their outcome; and it is he who can help when the sufferer does not know how to help himself. These are only a few of the general reasons; there are many more that might prompt us to take sides. Both viewpoints should at least be considered where the application of research is in question.

Some scientists argue that the sufferer does not need to participate in scientific investigations because the observer is able to "look with the eyes" of the sufferer. The importance of trying to see with the eyes of the other cannot be stressed enough: in trying to do so we frequently come closer to the view of the sufferer. However, a sharp distinction has to be made between the views of a person rising from his own position and the view he takes when attempting to see with the eyes of another. In trying to take the standpoint of the other, he cannot actually get into the other's position; and when he tries to look with the eyes of the other, he only imagines how the other perceives and evaluates matters. It is very important that the correspondence between the view of the observer taking the standpoint of the sufferer and the actual view of the sufferer *can* be checked. A simple and valid method is to ask the sufferer whether and in what way his views are correctly perceived by the outsider.

Traditional psychology is the one-sided psychology of a particular kind of observer, namely, an aloof, objective observer. The traditional psychologist, strictly behavioristically and observationally inclined, considers no other psychology but his to be scientifically legitimate. The scientific psychologist is ready to accuse his experimental subject of having a biased view, and he tends to reject the subject's statements as egocentric and emotional. Further, he believes that he himself is not emotional and evaluative in his choice of problems, selection of data, and method of dealing with problems. He believes he investigates what really exists, that he gets to the facts. In actuality, he sees things from a given angle, that of an objective observer whose observations are stripped of everyday connotations by his aloofness.

When the traditional scientist deals with values, he tries to treat them as facts and asserts that his own values do not influence his research. In actuality he feels and evaluates. His propensities are not filtered out from his research through the "factual approach," because being aloof is also an emotional state and he cannot escape evaluating. The investigator evaluates when he chooses what he believes is important to investigate and when he selects methods and procedures. His evaluation shows up clearly in his belief that he is a better investigator than the sufferer and other subjects. It shows up also in his disregard for their opinions, in his treating them as inarticulate objects. As long as the scientific psychologist decides on what should and should not be done, as long as he judges the importance

of matters, he evaluates. The "oughts" of traditional research–choice of the problem because of its theoretical importance, demand for objectivity in the performance of the research, the emphasis on dealing with reliable and most probable occurrences, and the like, all accepted as "oughts" by the scientific psychologist–are values guiding psychologists in what they do. Thus, what the aloof scientific psychologist does is not less value-directed and emotional than what is done by the "emotional" and "value-directed" sufferer: only the character of the feelings and values of the insider are different from those of the outsider.

**Inclusiveness of units**

That a difference exists between the feelings and values of the investigator and those of the sufferer should not just be accepted as fact: the differences must be taken into consideration in research. I will discuss one specific difference in the structure of the cognitive field of the investigator and sufferer: the difference in units encompassed by people in viewing matters from different distances.

All of us sometimes perceive a single thing, at other times a unit subsuming several units. The same holds for our thoughts; sometimes we think of a single object, at others of a unit subsuming a number of units. Sometimes we think of a tree, sometimes of a forest. This observation is not new, nor does it seem to be of special interest. However, systematic conditions accounting for differences in units encompassed by the investigator or sufferer lead, in rehabilitation, to serious consequences worthy of attention.

An examination of how the sufferer and investigator think shows that the sufferer thinks in less inclusive units than the scientifically trained professional observer. The statement holds for units of population and units of time, as well as for conceptual units. The sufferer tends to think about one sufferer, whether himself or another person; the scientific observer more easily thinks about handicapped people in general. Also, the sufferer wants help with an immediate problem, the observer is concerned with the future. Conceptually, the observer thinks more abstractly than the sufferer: when the mother of a retarded or severely handicapped child asks the specialist whether her child will improve, she means will he be able to sit up, but the specialist thinks the mother asks whether the child will reach normalcy.

The difference in units encompassed by the scientific observer and by the sufferer leads to serious misunderstandings. The kind of misconceptions and misunderstandings due to difference in units encompassed should be studied. The knowledge gained should then be taught to prospective professional persons.

The examples of different units encompassed are familiar. Two things, however, are novel about these units. First, the differences in the inclusiveness of units encompassed are not just a matter of individual differences among people or situations. These differences are related to the positions of the insider and the outsider. Second, the units that encompass a number of units in comparison with the single unit are frequently global, that is less detailed, and may appear superficial in comparison with the single unit.

As to the first point, we know that when the distance from an object perceived increases, a greater number of objects in the surrounding area enter the field of vision. So also in thinking, the inclusiveness of the unit encompassed depends on the distance of the person from the subject matter. The distance here, however, is not a geographic but an emotional distance that characterizes the insider as closer and the outsider as farther away from the subject matter. As in the case of visual perception, a person when close to a house can perceive only that house but going farther away can perceive a row of houses–so also a sufferer close to his problems is likely to think of himself; but a distant observer, even when facing a single handicapped person, is concerned with the whole group of handicapped people to which he believe the single sufferer belongs.

As to the second point, again let us consider a visual example. Houses running in a line, more or less, make up a street. Within the notion of street, the individuality of houses disappears. Similarly,the distant investigator deals with an abstract notion, that of a handicapped group, and leaves out the characteristics of individual persons. An outside investigator, thinking globally of abnormality, cannot understand a mother's carefully selecting a dress for her severely crippled child. Because of the global notion of normalcy, the professional person tends to conclude that it is not worth money and effort to improve the treatment of a profoundly retarded child. Of course the outside observer can focus on a single person and the insider can think about all handicapped persons, but these thoughts are not natural to them: the feeling of being the affected person or the detached observer brings about only an inclination toward thinking about particular units.

The subsumption of units, a psychological aspect of the world we live in, and the effect of the subsumption of units, aspects little taken into account in psychology, are of great importance in life. Teaching the professional

person to understand the differences between his views and those of the sufferer should lead to better understanding of the sufferer.

In using knowledge in the field of rehabilitation it is important who decides what kind of knowledge is valuable, that is, who investigates and who teaches. Usually the investigator and the teacher are outsiders, and the knowledge they gather or teach is primarily that of the outsider. The outsider is inclined to teach about large units, that is, about what seems to hold for most cases, and will value the knowledge arrived at from a large number of groups. This helps make him *quantitatively inclined* and interested in what happens in most cases and what has a greater chance of occurring in a new group of cases, though not necessarily in a particular case. The result of such training will make the practitioner use standard prescriptions (standards arrived at from knowledge about groups of cases and frequently not fitting the single case). Directed during his training toward the value of large units, he will measure his success by the *number* of cases he could help. Because he counts success by the number of cases, he will divide handicapped people into promising and hopeless cases. He will lean toward spending his time, whether in an institution or in a community, with groups of less severely handicapped persons and will give up treatment and reduce to the bare minimum the care of "custodial" or "hopeless" cases.

Teaching involving the view of the handicapped persons would be quite different. Handicapped people would not divide cases easily into those worth or not worth the effort. Every handicapped person, even with a relatively minor handicap, knows that he is considered "not normal" by some "nonhandicapped" people (that is, in regard to normalcy, is considered a hopeless case) and thus is cautious in classifying handicapped people as hopeful or hopeless, as worthy or unworthy of care. Even the relatively mildly handicapped person knows of many situations in which his abilities were underestimated, and therefore he was not given opportunities to do things. Some outsiders think quadraplegic persons are so severely handicapped they would not encourage them to become college teachers and, therefore, would not support their admission for study or recommend them for jobs. Also, outsiders think a person with an IQ of 20 is unable to profit from training in the activities of daily living. However, many handicapped persons believe that some quadraplegics and some persons with low IQ's can "make it." And they are right, as they know—it has been proved possible.

It is the handicapped person who will prompt the investigator to work at the frontiers of knowledge, where hopes rather than realistic expectations govern. He is ready to expect things to happen against realistic odds. In a situation in which the need for a desired occurrence is of paramount importance, he not only wishes it to happen, he also believes that it will happen and is ready to work against great odds. The sufferer gives up following the dictum of probability (that is, expecting the most probable to happen) and exchanges it for the dictum of the possible, expecting the exceptional outcome. Until now the scientific investigator in psychology has been concerned with the most probable outcome, making his estimates and predictions on the basis of the outcome in most cases. Because of the concern of the sufferer with the possible, the investigator will have to shift the emphasis to consideration of a range of possible outcomes, including the rarest. This necessarily will lead him away from high evaluation of the probability of occurrences to new views concerning quantification in psychology.

The stress to be placed on the participation of the handicapped person in selecting problems for research and methodological questions such as determining the range of possible occurrences, including the hardly possible outcome rather than the most probable, may lead some psychologists to this facetious question: Is there anything left for the psychologist to do? The answer: as important as it is to have handicapped people involved in research and its application, there is plenty for psychologists to do in rehabilitation. The viewpoint of the nonhandicapped partners in the relationship must be determined, if only because they possess the keys to the institutions in which many handicapped people are locked, because nonhandicapped people set up and administer the policies that determine the rights and benefits of handicapped people, because some of the nonhandicapped people are the medical and other professional people who can help the deprived and disabled, and because they are the neighbors, strangers, and coworkers whom handicapped persons meet. Professional people who are not handicapped have to be understood in interrelation with handicapped people. And if the handicapped person has something to contribute toward understanding his psychological ways of dealing with matters, so has the person not handicapped much to contribute to the understanding of how to deal with handicapped people. Last but not least, it is in the domain of the psychologist to puzzle over the relation between theories and facts in his own particular way.

## Lack of environmental opportunities

Possibility does not only designate a concept complementary to probability—it is also a synonym for opportunity. This is the case when we say "the possibility (or opportunity) was given to him to do what he wanted." Providing opportunity refers to the arrangement of environmental conditions. Perhaps for too long some psychologists in rehabilitation, when investigating and trying to use findings, have concentrated on the problems of a person's abilities without paying enough attention to environmental conditions, especially as set and kept by people. However, problems are frequently due to lack of environmental opportunities and, further, in a great number of cases their provision and also their lack are social-psychological in origin. Thus the outsider, being oblivious of the needs of the man in the wheelchair, unintentionally sets up architectual barriers. When his attention is drawn to the barriers, he can let them stay or remove them, that is, provide or not provide opportunities to the handicapped person.

Frustration as a situation in which attainment of the goal is made impossible is a worked and perhaps overworked topic in psychology. Considerable attention has been paid to the effects of deprivation. But the reverse—detection of opportunities, providing opportunities, and determining their effect—is hardly studied. Yet many frustrating situations would be eliminated if people would not deprive others of opportunities. Much of rehabilitation psychology, therefore, should consist in discovering and providing opportunities. Psychologists should be taught to survey social and physical environmental settings in regard to opportunities and to examine professional contacts, care, and treatment under this aspect. Any care given to the disabled should include checking whether needed opportunities have been given to the handicapped person as seen by the outsider and by the insider. Investigation of environmental conditions and use of knowledge are closely linked.

"Is the checking of the entrance to and exit from buildings a psychological problem?" Yes: blindness to hindrances and the provision of opportunities are psychological issues that require the psychologist's attention. For example, a prison, or any institution with residents behind locked doors, is characterized by restriction of freedom of movement and communication and by lack of opportunities to do things. More specifically: in an institution for the retarded, in a building for the profoundly retarded, the incidence of incontinence was very high. Afraid that the residents would stuff the toilets with objects and would be burned using the hot water, the staff kept the doors to the bathrooms locked and did not have time to open them frequently. What could the residents do but be incontinent? The psychological consequence was that they appeared more profoundly retarded than they actually were because they lacked the opportunity to remain clean.

To find solutions for such problems is not difficult intellectually and answers could be found by asking the insider, but professional workers require a lot of training and a lot of wisdom to change the conditions in such a building, that is, to provide opportunities to the residents for decent living. It is one of the most urgent tasks of rehabilitation psychologists and other professional workers not only to prepare residents in institutions for living in the community but also to provide opportunity for dignified living for those who have to remain in institutions. Detecting lack of opportunities and providing the opportunities is a part of proper custodial care. With the help of diverse social-psychological means the bare, restricting environment should be changed to one that presents needed opportunities.

## The Principal Points

The points I have been trying to make are briefly these:

- The use of knowledge in rehabilitation psychology is not primarily a question of application but requires the acquisition of relevant knowledge. Relevant knowledge involves taking for scientific investigation problems considered to be problems in everyday life.

- The use of research requires reevaluation of current scientific psychological approaches and methods. New theoretical views have been discussed.

- The unilateral view of the investigator as the one and only person to select problems for investigation and to investigate them is subject to challenge. Two views, that of the observer and that of the sufferer, have to be taken into account. In understanding both views, that of the handicapped person and that of the professional, we can arrive at utilizable knowledge.

- The need for coordinating two psychologies is necessary because of the different positions occupied by the professional worker and the sufferer. The difference in position, characterized by the distance from the problem, leads the insider and outsider to encompass different rehabilitation units.

- The outsider is usually concerned with more inclusive units—with abstract knowledge and theories rather than with the needs of an individual case, with large groups, with final

outcome, with abstract standards. He is removed from the problems of the individual sufferer, who feels he needs help here and now and seeks and welcomes signs of even the slightest improvement. Principles permitting the resolution of conflicts resulting from contrary feelings and evaluations of matters by the outsider and sufferer have to be developed and taught, if better use of knowledge is to take place.

- Although at present most psychologists are guided by the statistically most probable outcome, which they deem to be the realistic way of solving problems, the sufferer emphasizes the importance of the desirable but exceptional outcome and the necessity of dealing not only with promising cases but also with the whole range of cases, including those with hardly a chance of alleviation.

- The concept of opportunities needs to be used. The concern with and provision of opportunities are very important in considering care in institutions both for those who will leave them and for those who are expected to be under lifelong care. The meaning of "custodial care" has to change.

- Throughout, gaining and using knowledge require the common effort of the sufferer and the professional worker.

WHAT I HAVE PRESENTED is one way of thinking about how rehabilitation psychology can increase the use of its knowledge. There are different ways of attempting it, and all of them should be considered. I am not an eclectic but would welcome theoretical approaches by different investigators from different viewpoints. My own views are an outgrowth of the Field Theoretical Gestalt approach, known also as Topological Psychology, to which I adhere.

# Rural Home Repair in Eastern Kentucky
## A Local-State-Federal Demonstration

Jeffrey J. Kell

Housing in eastern Kentucky, as in much of Appalachia, typifies the plight of many families living in the region. The kinds of houses and the poor condition into which they have fallen make apparent the lack of money and poor social circumstances characteristic of the region. Through the narrow mountain valleys, strip settlements wind a mile or two along the roads and single houses dot the hollows and hillsides. The community center is often only a general store-post office. Here and there are towns of identical houses, marked by the sameness of their dwellings as being, or as having once been, coal mine towns. But no matter where they are located or what their history, many houses in the area are near collapse.

The fact that houses in the area are in disrepair has been frequently documented. In testimony before the Task Force on Poverty of the Committee on Education and Labor, U.S. House of Representatives, on May 12, 1969, the director of the Eastern Kentucky Housing Development Corporation (HDC) of the LKLP Community Action Council, an agency of the Office of Economic Opportunity (OEO),[1] cited these data:

> "The four counties [Leslie, Knott, Letcher, and Perry] . . . contain more than 90,000 residents and are the most densely populated rural nonfarm area in the United States. The population density, the dilapidated housing, and the economic situation together have created a rural slum reaching over an area of 1,450 square miles.
>
> "In the four counties 13,292 houses (56 percent) were built more than 30 years ago. More than 9,000 (38.9 percent) were built before 1950. Nearly half the housing . . . is classed as deteriorating or dilapidated. Nearly 14,000 homes (more than half) lack some or all plumbing. Seventy-two percent of the owner-occupied housing is valued at less than $5,000."

In a proposal entitled "A Comprehensive Program for the Elderly Poor in Twenty-Three Eastern Kentucky Counties," made to OEO, representatives of five eastern Kentucky community action agencies said of the housing situation in their counties:

> "An inordinate number of these substandard houses belong to the aged. Aging families generally have small fixed incomes. They are often reliant on the sporadic contributions of their offsprings, who have left the area. In most cases they simply are not financially able to keep their homes in good repair."

The LKLP Joint Home Improvement Project is a multiagency program designed to improve the living conditions of certain needy persons in Letcher, Knott, Leslie, and Perry Counties (LKLP) of eastern Kentucky. Most of the persons served receive assistance under the aid to the aged, blind, and disabled (AABD) program. The public assistance component of the project was established under Sec. 1115 of the Social Security Act to demonstrate how the home improvement provisions of Sec. 1119 of the Act could be put into effect. Sec. 1115 authorizes grants for demonstration projects in public assistance. The 1967 Social Security Amendments allow the Federal Government to help pay the costs of materials and labor incurred by State public assistance agencies for home repairs on a 50 percent matching basis, up to $500. The Project began in the fall of 1968. This article reports on the first 16 months.

Two groups of people are served by the Project: AABD recipients and certain other needy persons in the area whose homes need repairing and the workers who do the repairs. The average age of the recipients is 73; 23 percent of them are women who live alone. The workers are mostly unskilled, previously unemployed men—50 years of age or over—without other means of support.

The Sec. 1115 component of the project grew out of discussions on the proposal made to OEO for helping elderly poor people in 23 eastern Kentucky counties by representatives of the Farmers Home Administration (FHA) of the U.S. Department of Agriculture, the

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*This article is based on Spindletop's evaluation of the Sec. 1115 public assistance demonstration grant component of the LKLP (Letcher, Knott, Leslie, and Perry) Counties Joint Home Improvement Project sponsored by the Kentucky Department of Economic Security and supported by a grant from the Social and Rehabilitation Service.*

Manpower Administration (MA) of the U.S. Department of Labor, OEO's Community Action Program (CAP), and the Social and Rehabilitation Service (SRS) of the U.S. Department of Health, Education, and Welfare. As OEO could not support the entire project, an ad hoc interagency committee was set up to organize a cooperative development program for the area. Both the Kentucky Department of Economic Security (DES) and the LKLP Community Action Council, a CAP agency, supported the idea, partly because a study conducted by DES' Research and Statistics Department in 1965 showed the need for such a project.

### Project aims

The specific aims of the Sec. 1115 public assistance demonstration component of the Home Improvement Project are these:

- To show how "uninhabitable" homes owned by elderly, blind, and disabled persons can be made more habitable, safe, and sanitary for continued occupancy with financial assistance and coordinated agency effort.
- To demonstrate that elderly, unemployed, relatively unskilled men can do good home-repair work with reasonable efficiency and, in the process, acquire skill in a trade or occupation.
- To prove that Federal, State, and local agencies can coordinate their services to demonstrate the use of the provisions of Title II of the Economic Opportunity Act and Sec. 1119 of the Social Security Act in providing an effective joint home improvement project that could be followed in other States.
- To encourage public assistance staff members to attend to the housing needs of elderly, blind, and disabled persons.
- To develop a method of using community aides (housing assistance aides).
- To repair 900 substandard homes for elderly, blind, and disabled persons in a year.

### Contributing agencies

The agencies contributing most of the manpower and money for the project include SRS; CAP; the Outreach Program of the LKLP Community Action Council; DES; HDC; the Operation Mainstream Program of the U.S. Department of Labor; and FHA.

As part of its continuing community development activities, the Outreach Program of the LKLP Community Action Council has been conducting formal surveys of housing conditions in the LKLP area. Based on the results of these surveys, the DES Division of Public Assistance determines the potential eligibility for home repairs. As the surveys are part of the Council's community action program, no special funds are allocated for them.

An SRS grant of $622,000 to DES covers the costs of administering the project and purchasing the materials to repair 900 homes. The DES portion of the program is managed by a special staff, which works out of the public assistance offices of the four counties. DES staff responsibilities are to coordinate the project; determine the eligibility of project applicants; help select homes for repairs and determine what repairs are needed; deliver project-related social services to recipients; identify needs and make referrals; secure bids on materials and arrange for purchase and delivery to the sites; and inspect homes to control the quality of work and materials and to ensure that the owners are satisfied.

Materials are procured from dealers in the LKLP area. Most materials are not structural and are often "old-fashioned"—roll-brick siding and pine flooring. The disadvantages of not buying in bulk are offset by the limited supply of these kinds of materials outside the area and the good effect of local purchasing on the area's economy.

Key elements in the coordination and management of the project are the DES Participant Selection Committees—one for each county. Their main purpose is to evaluate data on potential project recipients and decide which houses are to be repaired, to what extent, and in what order. Through them, local organizations and community participants become involved in and keep informed about day-to-day operations. Each committee includes a DES project social worker or supervisor and representatives of the county health department, the LKLP Community Action Council, HDC, FHA, and a public assistance recipient not eligible for home repairs.

Homeowners can also obtain loans from FHA under the program for very low income homeowners authorized by Sec. 504 of the Housing Act of 1949, as amended. Local FHA officials process applications.

To accomplish the repair work, HDC obtained a CAP grant of about $674,000 to cover wages and equipment for 56 men, the primary work crews. HDC's specific responsibilities are to employ, train, and supervise unemployed, unskilled workers, 50 years old or older, and to supervise additional work crews from Operation Mainstream, which is conducting community improvement projects in eastern Kentucky, and coordinate their work. Under the Mainstream program, hard-core unemployed workers are eligible to receive classroom and on-the-job training and counseling and placement services. It is manned by program enrollees, some of whom are being served by the Eastern Kentucky Concentrated

Employment Program (CEP), also sponsored by the U.S. Department of Labor.

The project began with 26 enrollees; in September 1969 it had 88. The director of Operation Mainstream has administrative control of them; the director of HDC, functional supervision while they work on project houses. As work experience from the project is part of the Mainstream training program, no special funds are allocated to make enrollees available to the project.

### Use of paraprofessional workers

The use of paraprofessional workers to perform social services in the area is gaining widespread acceptance because of the lack of skilled, formally educated workers. Also, there is a growing realization in the social agencies that, for certain tasks centered on serving people, it is desirable to have local workers who understand the people with whom they are dealing. Because paraprofessional workers are usually unskilled, they work closely with specialists in a field. Together the specialist and the paraprofessional worker can cover a larger area than they can separately. This, coupled with the cultural familiarity the paraprofessional person brings, increases the effect of the task to be accomplished. An added benefit is that the paraprofessional worker's position gives him an opportunity to acquire special kinds of skill.

Three basic groups of paraprofessional workers are employed on the Sec. 1115 component of the project: housing assistance aides, repair workers, and outreach aides. The Division of Public Assistance employs housing assistance aides to demonstrate the use and upkeep of equipment installed as a part of the project. They act as consultants on home furnishing and home management needs to maintain the home for continued occupancy. HDC or Operation Mainstream employs the repair workers. Working in crews of eight under a supervisor, or crew chief, repair workers are responsible for repairing the houses while acquiring some skill in a trade. Outreach aides report directly to each county developer and are employed by the LKLP Community Action Council. The developers supervise community information and development activities for the Council. The aides disseminate information about Federal and State programs set up in the community. In addition, they conduct surveys of housing conditions in assigned communities and help members of the community meet their needs. All outreach aides are recruited from the LKLP area and are assigned to work with communities near their homes.

### Project results

The effects of the LKLP project have been good. It has accomplished a great deal for persons whose homes needed immediate repairs. Consequently, it has elevated the "government" in the eyes of the community, particularly because it links several programs and especially emphasizes State and local administration. Its influence has been more than local: it has stirred the interest not only of the Federal agencies involved but also of State and local agencies.

The LKLP project has operated efficiently, especially for a pilot demonstration project dependent on close interagency cooperation. One reason for its success is that its staff members are dedicated to service, whatever their level and whatever organization they are with. This attitude allows adjustments to be made when recipient needs are jeopardized by organizational restrictions and limitations.

After 16 months of operation, 545 houses had been improved of the 900 originally scheduled for the first 12 months. The failure to meet the schedule is primarily due to the lack of repair workers, the extensively dilapidated condition of many homes, and the additional time needed to complete the extra repairs supported by FHA loans.

FHA's Sec. 504 loans have been very popular with project recipients as a supplement to the $500 grant. Out of 545 houses repaired, 69 owners requested FHA loans and 49 received them, for an average of $705 per loan per home.

Unquestionably the project has affected many persons in the four-county area and so far the effects are all good. Almost without exception, recipients are pleased not only with the repairs as such but also with the thought that someone cares enough to help improve their living conditions. Groups and organizations also express the feeling that the project is accomplishing a great deal for persons who badly need help. About 98 percent of a sample of 108 community leaders had almost no criticism. So nearly unanimous a response makes it reasonable to assume that community opinion is highly favorable. Many community leaders said that the $500 allowance for materials should be increased, more work crews should be added, and eligibility should be broadened to include many poor persons not now eligible.

The broad effects of the project include these:

- Genuine appreciation of the improvements by project recipients.

- Greatly improved living conditions and the removal of many health and safety hazards.
- Productive work for the unemployed.
- High quality repair work by the repair crews.
- Almost universal community support.
- Increased revenue and business in the LKLP area.
- Creation of a greater demand for FHA loans among people who need them most.
- Creation of a backlog of applications (evidence that news about the project, and of the satisfaction of those it is serving, has spread).

The specific effects on homeowners include these:

- Before repairs were made, about 20 percent of the homeowners wanted to move to new or better dwellings. After repairs, this percentage decreased to 10 percent.
- Most recipients indicated that they had more visitors after their homes were repaired. In addition, many other persons repaired their homes as a result of the improvements to recipients' homes.
- Many recipients contributed part of their savings for additional home-repair materials. As of December 1969, they had committed $17,720, for an average of $132, for each recipient who contributed.
- All recipients were satisfied with the quality of materials and the manner in which they were purchased.

The home improvement repairs that have been most often made include repairs to inside walls, porches, roofs, floors, and insulation. The need the project has been least able to satisfy is the installation of running water and bathroom facilities.

An important aspect of the project has been its ability to use unskilled and older local workers through OEO and MA programs. The constructive jobs made available by this project have allowed individual workers to earn income while acquiring semiprofessional or special skill. This is especially important because of the lack of employment opportunities available to this kind of worker and the limit on funds for labor and materials ($500 per family).

The repair workers register their satisfaction with the project by very low absentee and sick leave rates. In answer to specific questions regarding the project, about 75 percent of the workers and crew chiefs said that the best part of the project was being able to help people who could not help themselves obtain better living conditions. In addition, 99 percent of them said they liked repairing houses. When workers and crew chiefs were asked whether they had acquired occupational skill through the project, about 80 percent said they had, mostly as carpenter's helpers.

As to economic effects, it is estimated that the project will have increased the income of the LKLP area by $1.8 million and of Kentucky by $2.5 million over the first 2 years of operation. As a result of project spending in the area and in the State, a total direct and indirect employment of 220 persons will be created over the life of the project.

**What lies ahead**

One fact that has become clear from this look at the first 16 months of the project is the need for the program to be made permanent. By estimate, about 500 persons will be added to the State's AABD program during 1970 in the LKLP area. Of them, 200 could be potentially eligible for service under the public assistance component of the LKLP Joint Home Improvement Project. These estimates point up the need for a means of serving elderly, blind, and handicapped persons as they become eligible for public assistance.

The project has proved to be highly successful by most standards. It is an action program, producing results under existing legislation and using existing organizations and manpower. Although the repairs are limited, they are removing a great deal of the hazards to the health and safety of hundreds of people.

Despite these and other achievements, there is a need for changes in the program. For example, the $500 maximum allowance is not sufficient to cover the costs of materials—even though it was intended to pay for both materials and labor. The ceiling should be raised because the average cost of labor runs about $1,000 per house. Eligibility should be broadened to include other needy groups of persons besides the elderly, blind, and disabled: Social Security beneficiaries, mothers receiving assistance under the aid to families with dependent children (AFDC) program, and the husband or wife of an eligible recipient (homes owned in fee simple).

Similar programs could be developed in other counties and States by reproducing the basic design of this project to fit the particular needs and resources of each situation. The economic effect alone would be sufficient reason to justify its widespread adoption, but the prime justification is being able to provide immediate assistance to people for whom a long waiting period could be disasterous.

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[1] *HDCs, supported by funds from OEO, are organized and staffed by local people. Their purpose is to improve existing housing in low income areas and to increase the supply of low income housing.*

# How Employable Are AFDC Women?

Perry Levinson

Employment training programs and economic incentives such as the current earnings exemptions aimed at encouraging public assistance recipients to seek and hold jobs presuppose that a large segment of the women receiving assistance under the aid to families with dependent children (AFDC) program are able-bodied and in a position to seek and take jobs that pay well. This article presents estimates of the degree to which AFDC women are in fact employable, based on data from several studies conducted by the Social and Rehabilitation Service of the U.S. Department of Health, Education and Welfare.

To arrive at the estimates, the concept of employability was divided into two separate aspects. The first, *employment potential,* involves the background conditions that a prospective employer is most likely to use in evaluating a job application, including one from an AFDC woman—level of education and type of previous employment. The second, *employment barriers,* involves the conditions that could keep an AFDC woman from even applying for a job: poor health, lack of day care facilities, high unemployment or lack of jobs for which she is qualified, psychological problems, and the like. Estimates for *employment potential* are available for the 1961, 1967, and 1968 AFDC caseloads.[1] Estimates for *employment barriers* are available for the 1968 caseload only.

## Employment potential

Employment potential was considered as *low* or *high* according to the categorization scheme shown in table 1. By the standards used, the women who fell into cells 1, 2, 3, or 4 had *low* employment potential. Most of them had never been employed or had been employed at unskilled blue-collar jobs only such as domestic service, farm labor, and food service and had less than a high school education. However, the category *low* potential does not mean complete unemployability. Regardless of the women's employment backgrounds, those who fell into cells 5 through 12 had *high* employment potential because they had at least a high school education or, if they had less education than that, had worked as skilled blue-collar workers—as craftsmen, machine operators, and the like—or as white-collar workers—as file clerks, saleswomen, secretaries, and the like.

**Table 1. Years of education, by level of employment**

| Level of employment | Years of education completed | | |
|---|---|---|---|
| | 0-8 | 9-11 | 12+ |
| Never employed | 1. Low | 3. Low | 5. High |
| Unskilled blue-collar worker | 2. Low | 4. Low | 6. High |
| Skilled blue-collar worker | 7. High | 9. High | 11. High |
| White-collar worker | 8. High | 10. High | 12. High |

By random distribution a third (4/12ths) of the caseload would have had *low* potential and two-thirds (8/12ths) *high* potential. But actually, instead of only one in three falling into the four *low* potential categories, the distribution of the recipients in the low and high groups was as follows:

| Potential | 1961 (Percent) | 1967 (Percent) | 1968 (Percent) |
|---|---|---|---|
| Low | 74.6 | 67.4 | 55.5 |
| High | 25.3 | 32.6 | 44.5 |
| Total | 99.9 | 100.0 | 100.0 |

The 1961, 1967, and 1968 distributions of women by the 12 categories are shown in table 2.

The proportion of AFDC women having *high* employment potential significantly increased between 1961 and 1968 (though the 1968 proportions are the best available, they are approximate only, because they represent only 35 counties out of the over 3,000 in the United

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Table 2. Employment potential of AFDC women, 1961, 1967, United States, and 1968, selected counties

| Education and occupation, by employment potential category | | | Year | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 1961 | | 1967 | | 1968 | |
| Category | Education | Occupation | Number | Percent | Number | Percent | Number | Percent |
| 1. | 0-8 | Never employed | 121,300 | 19.6 | 133,200 | 14.4 | 525 | 7.0 |
| 2. | 0-8 | Unemployed, blue-collar | 179,900 | 29.1 | 207,700 | 22.5 | 1,848 | 24.8 |
| 3. | 9-11 | Never employed | 50,800 | 8.2 | 86,400 | 9.4 | 273 | 3.6 |
| 4. | 9-11 | Unemployed, blue-collar | 109,300 | 17.7 | 194,700 | 21.1 | 1,498 | 20.1 |
| 5. | 12+ | Never employed | 16,100 | 2.6 | 27,300 | 3.0 | 52 | 0.7 |
| 6. | 12+ | Unemployed blue-collar | 46,700 | 7.6 | 84,400 | 9.1 | 536 | 7.2 |
| 7. | 0-8 | Skilled, blue-collar | 22,100 | 3.6 | 25,500 | 2.8 | 771 | 10.3 |
| 8. | 0-8 | White-collar | 6,300 | 1.0 | 5,700 | 0.6 | 80 | 1.1 |
| 9. | 9-11 | Skilled, blue-collar | 16,600 | 2.7 | 34,500 | 3.7 | 863 | 11.6 |
| 10. | 9-11 | White-collar | 15,100 | 2.4 | 36,500 | 4.0 | 296 | 4.0 |
| 11. | 12+ | Skilled, blue-collar | 8,700 | 1.4 | 19,400 | 2.1 | 308 | 4.1 |
| 12. | 12+ | White-collar | 25,000 | 4.0 | 67,500 | 7.3 | 415 | 5.6 |
| Total [1] | | | 617,900 | 100 | 922,800 | 100 | 7,465 | 100 |

[1] *The 1961 and 1967 totals are estimates inflated from samples. The 1961 totals exclude 123,900 "unknown information" cases (16.7 percent of all cases); the 1967 totals exclude 218,800 "unknown information" cases (19.2 percent of all cases). The 1968 total is the number of AFDC women surveyed in the National AFDC Study, excluding 135 "unknown information" cases (1.8 percent of the survey sample). The 1961 and 1967 totals are accurate estimates; the 1968 data can be used only as an approximation of the proportions in each of the 12 categories.*

States). The improvement in employment potential occurred among all major subcategories of the AFDC caseload–urban women, rural women, women under 30 years of age, and women 31 and over, as shown in table 3.

The women 30 years of age and under and the women living in urban areas were better educated and had "better" occupational skill. They made the most significant gains between 1961 and 1967; those living in rural areas and those 31 years of age and over made the smallest gains. Though the data indicate a continued upward climb in the percentage of recipients with *high* employment potential in most categories, they also indicate that recipients in rural areas and those 31 years of age and over were far behind those living in urban areas and those under 31 years of age.

Table 3. Percent of AFDC women having high employment potential, by urban or rural residence and age (under 31 and 31 and over), 1961, 1967, and 1968

| Characteristic | Year | | |
|---|---|---|---|
| | 1961 | 1967 | 1968 |
| Urban | 28.5 | 35.1 | 46.8 |
| Rural | 15.6 | [1] 19.2 | 34.4 |
| Under 31 | 28.2 | 38.2 | 50.8 |
| 31 and over | 23.9 | 29.0 | 40.8 |
| Total caseload | 25.3 | 32.6 | 44.5 |

[1] *This should be read: In 1967, 19.2 percent of all AFDC women living in rural areas had high employment potential and, therefore, 80.8 percent low potential.*

The percentages were not uniform throughout the country. For example, among recipients coming from urban areas, the percentage of recipients with high employment potential in 1968 for 11 cities was as shown in table 4.

Of the 11 cities, Providence had the greatest percentage of AFDC women with high employment potential (74.4), Memphis the least (20.5). The sharp difference might reflect the general educational level in the two communities, but a rank order comparison showed no

Table 4. Employment potential of AFDC women in 11 cities (percentages)

| City | Percent of recipients with high employment potential | | Percent of all women, age 25 and over, in 1960 with high school education or more | | Eligibility restrictiveness score[1] | |
|---|---|---|---|---|---|---|
| | Percent | Rank | Percent | Rank | Score | Rank |
| Providence, R.I. | 74.4 | 1 | 32.4 | 10 | 4 | 4 |
| New York City, N.Y. | 64.8 | 2 | 42.8 | 5 | 2 | 2 |
| Rochester, N.Y. | 57.0 | 3 | 43.8 | 4 | 2 | 2 |
| Chicago, Ill. | 56.2 | 4 | 39.9 | 8 | 7 | 7.5 |
| San Jose, Calif. | 52.4 | 5 | 56.6 | 1 | 2 | 2 |
| Philadelphia, Pa. | 43.4 | 6 | 30.6 | 11 | 5 | 5 |
| Atlanta, Ga. | 38.2 | 7 | 41.5 | 6 | 6 | 6 |
| New Orleans, La. | 30.4 | 8 | 33.2 | 9 | 9 | 10.5 |
| Phoenix, Ariz. | 28.7 | 9 | 49.6 | 3 | 8 | 9 |
| Raleigh, N.C. | 27.3 | 10 | 49.7 | 2 | 7 | 7.5 |
| Memphis, Tenn. | 20.5 | 11 | 40.9 | 7 | 9 | 10.5 |

[1] *Score computed according to formula devised in 1968 National AFDC Study, Bureau of Social Science Research, Inc., Washington, D.C.*

relation (-.164 Kendall Tau) to number of women 25 years old and over who had at least a high school education in 1960, the closest year for which data are available.

A study of eligibility policies in 10 of the 11 cities (all except New York), conducted in 1968 through a scale measuring *mobility potential* (MP),[2] had determined the standing of the cities. Knowing from this study that the cities varied according to the restrictiveness of their eligibility policies, the rank of the percentages of AFDC women with *high* potential and the rank of their scores for restrictiveness of eligibility were compared. The results were statistically significant (.584 Kendall Tau, significant at the .05 level).

With these data in hand, it was then possible to test the relation between level of potential and level of restrictiveness, *controlling* for general level of education. A Kendall partial rank correlation was computed, resulting in a correlation of .652. Even taking into account the fact that educational attainment differs in the 11 cities, eligibility policies as applied by local welfare departments were a significant determinant of the proportion of women with *high* employment potential in the AFDC caseload. Recipients with *high* employment potential are systematically denied public assistance in the cities with restrictive eligibility policies.

The restrictiveness study computed MP for active, closed, and denied cases. The percentage of high MP cases among denied cases was divided by the percentage of MP cases among the active cases (see table 5). These ratios were ranked and compared with the ranking of the city's eligibility restriction score to determine whether high MP cases were systematically excluded. The rank order correlation was .68 (significant at the .05 level), a figure strongly indicating that restrictive States overzealously apply restrictions to the *high* not the *low* MP cases.

The percentage of *high* MP cases among closed cases was divided by the percentage of *high* MP cases among active cases, again using the active cases as the standard. These 10 ratios were ranked in order and compared with the rank of the restrictive scores to determine whether high MP cases were being systematically forced off the AFDC caseload. The rank order correlation was .47 (*not* statistically significant at the .05 level), a figure pointing up the fact that once *high* MP cases are allowed into the AFDC program, they leave at about the same rate in all 10 cities (there were about 50 percent more *high* MP cases among the closed cases than among *high* MP cases in the active caseload).

Table 5. Percentage of high mobility potential cases in active, closed, and denied caseloads, 10 cities, 1968

| City | Active (percent) | Closed (percent) | Denied (percent) |
|---|---|---|---|
| Rochester, N.Y. | 49 | 70 | 65 |
| Providence, R.I. | 50 | 68 | 47 |
| Philadelphia, Pa. | 36 | 50 | 52 |
| San Jose, Calif. | 45 | 64 | 68 |
| Chicago, Ill. | 42 | 63 | 60 |
| Raleigh, N.C. | 14 | 32 | 36 |
| Atlanta, Ga. | 22 | 39 | 32 |
| New Orleans, La. | 18 | 28 | 36 |
| Phoenix, Ariz. | 26 | 36 | 42 |
| Memphis, Tenn. | 14 | 28 | 30 |

To determine to what extent the two mobility groups really were different and possessed attributes justifying their classification as either *high* or *low*, the following tests were run on the 1968 sample of AFDC women, the only group for which evidence was available:

- After talking with a recipient for an hour, the interviewers classified her (based on her ability to understand simple interview questions) as "smart" or "not smart." Fully 64.9 percent of the recipients *later* classified as having *high* employment potential were rated by the interviewer as "smart," but only 48.8 percent of the *low* potential group were so rated.
- The interviewers also estimated whether the respondent could, with "some training," get a job as a waitress, saleswoman, interviewer, clerk, or secretary. Only 26.4 percent of the *high* potential group was rated as incapable of holding *any* of these jobs, but fully 51.5 percent of the *low* potential group was rated as incapable of holding *any* of these jobs.
- The interviewers noted whether the recipients could read simple sentences written on cards presented as part of the interview—4.7 percent of the *high* potential group could not, but in the *low* group the percentage was 12.
- The recipients were also asked whether they were employed—19.2 percent of the *low* potential group and 18.8 percent of the *high* potential group said they were. These differences are small and favor the *low* potential recipients, possibly because of the kinds of employment barriers confronting *both* groups.
- The recipients were asked to name the highest hourly wages they had ever received. Fully 59 percent of the *low* potential group had received highest hourly wages of *less* than $1.25, but the wages of only 26 percent of the *high* potential group had been that low.

This independent evidence validates the division of the two groups into *low* and *high* employment potential. Only for the percentage currently employed were the two groups similar, an aspect discussed in the next section.

### Barriers to employment

No matter what the recipient's potential, many conditions might prevent even those with the most education and experience from applying for work.

Data on employment barriers are available for the 1968 study only. In that study the persons interviewed were asked questions about 12 conditions that could seriously limit or completely prevent employment.

1. **General poor health:** "Yes" as an answer to the question, "Are there some kinds of jobs you can't get because of your health?" indicated poor general health.

2. **Serious health problems:** "Yes" as an answer to the question, "Does your health keep you from working altogether?" indicated a serious health problem.

3. **Low motivation to work:** "No" as an answer to the question, "Would you want to work if you could find a steady job?" indicated lack of motivation.

4. **Poor availability of day care:** "Don't know," "No one," or "I don't have anyone" as an answer to the question, "If you were to go to work who would take care of the children?" indicated the lack of day care facilities.

5. **Dissatisfaction with day care facilities:** "Not too well" as an answer to the question, "How well do you think your child would be taken care of if you made these arrangements (above question)?" indicated dissatisfaction with available day care facilities.

6. **Young children in the family:** "Yes" as an answer to the question, "Do you have any children under 8?" indicated the presence of young children in the family.

7. **Awareness of poor labor market:** "No jobs available for me" or "Can't get a job that would pay enough to live on" as an answer to the question, "What is keeping you from working?" indicated that the recipient was aware of poor labor conditions in her community.

8. **Needed to care for children at home:** "My children need me at home" or "I don't think I should leave my children until they are older" as an answer to the question, "What is keeping you from working?" indicated the recipient thought her children needed her at home.

9. **Needed in the home for special health care of a family member:** " I have an ill aged person or child who needs me to care for them" as an answer to the question, "What is keeping you from working now?" indicated that the recipient had an elderly person or ill child to care for.

10. **Lack of self-confidence:** A score of 0, 1, or 2 on a self-esteem index indicated the recipient lacked confidence. The index was made up of such questions as these: "Would you describe yourself as slow or fast?" "Dependable or not dependable?" "Not so smart or smart?" "Happy or unhappy?" and "Dull or sharp?"

11. **Mistrust and depression (alienation):** A score of 4 or 5 on an alienation index indicated that the recipient was depressed and distrustful of others. The index contained such statements as these: "Most people don't really care what happens to the next fellow"; "You can't be a success in business or politics without taking advantage of people"; "It's hardly fair to bring children into the world with the way things look for the future"; and "If you want a government job, having pull and knowing somebody are more important than ability."

12. **A feeling of being unable to do anything about social environment (powerlessness):** A score of 5 or 6 on a powerlessness index indicated that the recipient felt powerless (the score was based on negative answers to such questions as these: "If the welfare department is taking too long to let you know its decision, could you do anything about it?" and "If you were not able to get good medical care, could you do anything about it?").

The *low* and *high* employment potential groups scored as shown in table 6.

The proportion of recipients who had any given impediment to employment was—unexpectedly—similar

Table 6. Scores of low and high potential groups of AFDC women for conditions limiting or preventing employment (percents)

| Condition | Group | |
|---|---|---|
| | Low potential (percent) | High potential (percent) |
| 1. Poor general health | 45.9 | 37.6 |
| 2. Serious health problems | 23.1 | 15.4 |
| 3. Low motivation to work | 19.6 | 19.6 |
| 4. Poor availability of day care | 51.0 | 50.2 |
| 5. Dissatisfaction with day care | 15.0 | 14.8 |
| 6. Young children | 76.6 | 81.7 |
| 7. Poor labor market | 12.5 | 13.7 |
| 8. Needed at home | 24.8 | 24.5 |
| 9. Needed to care for ill or aged family member | 8.0 | 6.1 |
| 10. Low self-esteem | 41.5 | 33.2 |
| 11. High alienation score | 27.6 | 35.6 |
| 12. High powerlessness score | 21.1 | 34.2 |

for both groups. For both groups, the first ranking impediment was having children under 8 years old at home, the second was the poor quality or lack of day care facilities, and the third was poor general health (severe enough to prevent them from "taking some kinds of jobs").

Many women had more than one employment barrier, as tables 7 and 8 show. About a third of both groups had two or fewer employment impediments, a third three, and a third four or more. The high potential group had considerably more members with four or more problems (29.5 percent of the low potential had four or more problems, but 37.5 percent of the high potential group had four or more problems).

Table 7: Cumulative number of employment barriers, by employment potential, 1968

| Number of barriers | Employment potential | | | |
|---|---|---|---|---|
| | Low | | High | |
| | Number | Percent | Number | Percent |
| 0 | 36 | 1.1 | 28 | 1.3 |
| 1 | 258 | 7.7 | 192 | 7.1 |
| 2 | 899 | 26.7 | 598 | 22.2 |
| 3 | 1,179 | 35.0 | 867 | 32.2 |
| 4 | 613 | 18.2 | 604 | 22.4 |
| 5 | 260 | 7.7 | 285 | 10.6 |
| 6 | 96 | 2.8 | 95 | 3.5 |
| 7 | 23 | 0.7 | 21 | 0.8 |
| 8 | 2 | 0.1 | 6 | 0.2 |
| 9 | 0 | 0.0 | 0 | 0.0 |
| 10 | 0 | 0.0 | 0 | 0.0 |
| 11 | 0 | 0.0 | 0 | 0.0 |
| 12 | 0 | 0.0 | 0 | 0.0 |
| Total | 3,366 | 100.0 | 2,696 | 100.0 |

Table 8: Cumulative number of employment barriers, by employment potential, 1968 (in percentages)

| Number of barriers | Employment potential | |
|---|---|---|
| | Low | High |
| 0-2 | 35.5 | 30.6 |
| 3 | 35.0 | 32.2 |
| 4+ | 29.5 | 37.5 |
| | 100.0 | 100.0 |

## Summary

The picture that emerges from the analysis of the data on AFDC women in 11 cities is that, though the employment potential of AFDC women (as measured by their educational and occupational attainment) markedly improved between 1961 and 1968, the high employment group had to face just as many, if not slightly more, barriers to employment. This finding seems to indicate that, as the AFDC caseload grew ever larger between 1961 and 1968, recipients were more and more women who had stronger educational and occupational backgrounds, that is, had *high* employment potential. But these women, despite their potential, had as many serious problems blocking full employment as women with *low* potential, if not more.

As a byproduct of the analysis, the study found that eligibility policies did act to exclude *high* potential women. Once on assistance, however, the proportion of *high* potential women who dropped out of the program was twice as high as the proportion of such women in the active caseload; but their dropping out was not the result of agency eligibility policies.

[1] *Robert Mugge, Acting Chief of the National Center for Social Statistics, Social and Rehabilitation Service, provided the data from the 1961 and 1967 AFDC Characteristics Studies. The data for 1968 were obtained from the National AFDC Study, a home interview survey including 7,602 active AFDC cases, conducted by the Bureau of Social Science Research, Washington, D.C., under a contract awarded by the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. Staff members of the Office of Research and Demonstrations, Social and Rehabilitation Service, were involved in the planning and conduct of the survey.*

[2] *Jennie McIntyre and Samuel M. Meyers,* Welfare Policy and Its Consequences for the Recipient Population: A Study of the AFDC Program *(Washington, Dec. 1969), U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Office of Research, Demonstrations, and Training.*

# Family Supportiveness in the Rehabilitation of Delinquent Boys

IN THE USUAL STUDY of juvenile delinquency, the research is concentrated on the delinquent to the neglect of the family.[1] Consequently, there is little rigorous research on the family and delinquency.[2] The lack of studies on this aspect led to a 1967-68 study conducted by the Department of Youth Resources, Town of Brookline, Mass., concerning the influence of the family on the rehabilitation of delinquent boys. The study was supported in part by a grant from the Social and Rehabilitation Service and conducted at the Shirley Industrial School for Boys, a State institution.

## Background

The Shirley study was conducted to investigate family interaction and changes in the behavior of a selected group of boys, institutionalized as delinquents. To this end, the marriage adjustment and child-rearing practices of their parents were correlated with rehabilitative changes in the boys. The major hypothesis of the study was that institutionalized boys from psychologically supportive families make greater progress in rehabilitation than those from homes offering little psychological support.

These definitions were used:

**Progress in rehabilitation.** A boy was making progress in rehabilitation when his behavior was consistently acceptable; his relationships with other boys and staff members were appropriate; he did things for himself such as beginning a correspondence course; he could converse with the counselor comfortably; he was willing to work and to accept supervision and suggestions and was adjusted to commitment; he was acquiring a more realistic self-image; his responses to events were more appropriate; and his role in his peer group was moving from passivity to involvement.

**Supportive family.** The supportive family was integrated and encouraged the individual growth of its members. The parents were adjusted to marriage and warm and accepting toward their children, moderate in protectiveness and discipline, and neither highly indulgent nor rejecting.

**Nonsupportive family.** The nonsupportive family lacked integration and did not encourage individual growth. The parents were not adjusted to marriage, could not help their children solve problems, and were over-indulgent, rejecting, and extreme in protectiveness and discipline.

The sample consisted of 87 Shirley boys and their families. Each boy met three criteria: he was living with both parents at the time of commitment;[3,4] he was not brain-damaged;[5] and he was not mentally retarded.[3,6]

## Procedure

Using data gathered through structured interviews with parents and from institutional records, tests, and evaluations, the boys were designated as coming from families ranked from high to low for supportiveness. Of the 87 families included, 30 were ranked as high, 27 as average, and 30 as low.

To determine the boys' intelligence, personality characteristics, and "progress" in rehabilitation, these instruments were administered to them: Wechsler Adult Intelligence Scale, Personality Orientation Inventory,[7] and Youth Behavior Evaluation Form.[8]

The parents completed these data-gathering devices: Maryland Parent Attitude Survey,[9] Marriage Adjustment Inventory,[10] Family Information Sheet,[8] and Family Appraisal Guide.[9] The results of the first two were converted into 6-point Likert-type scales and coupled with another 6-point Likert-type-scale of estimates of family support made from home visits, record evaluations, and parole officers' home reports.

To determine whether a boy's progress in rehabilitation was correlated with family supportiveness, shifts in his behavior while at Shirley were examined, by having the counselors evaluate the boys on the Youth Behavior Evaluation Form 3 months after admittance and again just before discharge. Verification estimates of "total progress in rehabilitation" on a 6-point Likert-type scale were part of the counselor's score determination. The data pertaining to shift in behavior were distributed and differences in means analyzed.

The "supportiveness" and "progress in rehabilitation" values derived from the data-gathering instruments were employed to test the major hypothesis and to analyze the differences between group scores by such variables as age, grade, and intelligence. Statistical checks for significant differences between supportive and nonsupportive families were made for such variables as age and education of parents and family income.

**Editor's Note**
The complete report of this study will be issued as a book, *The Treatment of Male Delinquents–A Study of Their Families*, by D. C. Heath and Company (Lexington, Mass.), in January 1971.

Data pertaining to the variables of age, grade, IQ, race, religion, offense, and number of brothers and sisters, as well as parental marriage status and employment patterns, were gathered and differences of means analyzed (table 1). Family descriptive data, pertaining to the variables of age, education, employment, socioeconomic level, remarriage, family size, race, and religion, were also gathered and differences of means analyzed (table 2).

## Findings

The analyses of the data produced these findings:

- The average boy from a supportive home was 16.4 years old, had 8.9 years of school and an IQ of 97.7, and was white and Catholic (table 1). His family had 4.97 children, including him (national average, 3.2). Family income was in the lower middle bracket. His father was 45.3 years old, his mother 43.1 (normal differences in U.S. population). His father had completed 9.8 grades of school, his mother 9.7 (table 2).

- The average boy from a nonsupportive family was 17.3 years old, had 8.3 years of school and an IQ of 95.4, and was white and Catholic. His family had six or seven children, including him. Family income was also in the lower middle bracket. His father was 46 years old, his mother 40.6. His father had completed 8.9 grades of school, his mother 9.4 (table 2).

- Although the IQ's of the boys from nonsupportive homes were significantly lower statistically than those of the boys from supportive homes, there was no practical difference. Moreover, when IQ's were correlated with "progress" in rehabilitation, there was no significant relationship in either group.

- The employment patterns (full and part-time ratios) of the supportive and nonsupportive parents were comparable, but significantly more nonsupportive families were in the low income bracket.

- Boys in both groups were comparable in race, education, religion, family size, and number of parents.

- Of the 15 variables correlated with "progress," 14 were not significant. The only significant relationship was between the educational level and the "progress" in rehabilitation for the boys in the nonsupportive families. It appears that, of the boys from nonsupportive families, those with the best adjustment to school made the most progress in rehabilitation.

**Table 1. Data analyses for delinquent boys, by family classification, for age, grade, IQ, race, religion, offense, size of family, and stepparents**

| Data classification | Family classification | | | | Statistics | |
|---|---|---|---|---|---|---|
| | Supportive | | Nonsupportive | | t-test | Level[1] |
| | Mean | Total | Mean | Total | | |
| Age | 16.4 | | 16.3 | | .47 | N.S. |
| Grade | 8.9 | | 8.3 | | 1.88 | N.S. |
| IQ | 97.7 | | 95.4 | | 2.07 | .05 |
| Race | | | | | | |
| White | | 28 | | 28 | | |
| Negro | | 2 | | 2 | N.C. | N.S. |
| Religion | | | | | | |
| Catholic | | 24 | | 22 | N.C. | N.S. |
| Protestant | | 6 | | 8 | | |
| Offense | | | | | | |
| Car theft | | 8 | | 10 | N.C. | |
| Breaking and entering | | 9 | | 5 | 2.99 | .01 |
| Assault and battery | | 3 | | 2 | N.C. | |
| Larceny | | 3 | | 6 | 1.59 | N.S. |
| Other | | 7 | | 12 | 1.89 | N.S. |
| Brothers and sisters | | | | | | |
| None | | 1 | | 1 | | |
| 1-2 | | 12 | | 6 | | |
| 3-4 | | 6 | | 9 | | |
| 5-6 | | 6 | | 6 | | |
| 7 or more | | 5 | | 8 | | |
| Stepparents[2] | | | | | 1.87 | N.S. |
| Fathers | | 1 | | 13 | | |
| Mothers | | 4 | | 2 | | |

[1] *To be significant at .05 and .01 levels, t values had to exceed 2.00 and 2.66 (Downie and Heath, table 3, 1959).* [2] *Three supportive families were foster, making 11 parents who were not the boys' natural parents.*

- The hypothesis that institutionalized delinquent boys from psychologically supportive families would make greater progress in rehabilitation than those from psychologically nonsupportive families was supported by three detailed analyses of the criterion variable. At the time of discharge from Shirley, the boys from supportive homes had a significantly higher mean score (63.8 with a standard deviation of 11.5) on the Youth Behavior Evaluation Form than the boys from the nonsupportive homes (57.1 with a standard deviation of 11.9). See table 3. At discharge, these two means differed significantly at the .025 level. Boys from supportive families had significantly higher progress scores ($t=2.22$; $P<.025$). In addition, they maintained or achieved top scores at a significantly higher level (Chi square=23.89; $P<.001$). Finally, they also had a significantly greater number of top scores at the second evaluation. Although a substantial number of the boys from nonsupportive homes had the same or higher scores on the second evaluation, they had greater opportunity to so score because fewer of them had made top rating on the first evaluation.

- In brief, though boys from both groups showed gains, those from support-

**Table 2. Data analyses for families of delinquent boys, by supportive and nonsupportive classifications, for age, education, employment, income level, remarriage, and size of family**

| Data classification | Family classification | | | | Statistics | | |
|---|---|---|---|---|---|---|---|
| | Supportive | | Nonsupportive | | t-test | Chi Sq. | Level[1] |
| | Mean | Totals | Mean | Totals | | | |
| Age | | | | | | | |
| Fathers | 45.1 | | 46.0 | | .47 | | N.S. |
| Mothers | 43.1 | | 40.6 | | 1.71 | | N.S. |
| Education | | | | | | | |
| Fathers | 9.8 | | 8.9 | | 1.53 | | N.S. |
| Mothers | 9.7 | | 9.4 | | .55 | | N.S. |
| Employment | | | | | | | |
| Fathers | | | | | | | |
| Full-time | | 26 | | 27 | | N.C. | |
| Part-time | | 1 | | 1 | | | |
| Mothers | | | | | | | |
| Full-time | | 9 | | 10 | | | |
| Part-time | | 6 | | 5 | | | |
| Income level[2] | | | | | | | |
| Lower middle | | 16 | | 5 | 2.92 | 7.32 | .01 |
| Lower | | 14 | | 25 | | | |
| Remarriage[3] | | | | | | | |
| Fathers | | 1 | | 13 | | 2.54 | N.S. |
| Mothers | | 4 | | 2 | | | |
| Size of family | | | | | | | |
| 1-2 | | 6 | | 2 | 1.39 | | N.S. |
| 3-4 | | 9 | | 9 | | | |
| 5-6 | | 8 | | 8 | | | |
| 7 or more | | 7 | | 11 | | | |

[1] *To be significant at the .05 level, t value had to exceed 2.00 and Chi-square had to exceed 3.84 (Downie and Heath, tables 3 and 4, 1959).* [2] *Under $7,500 a year was considered "lower."* [3] *In addition, three boys from supportive homes had foster parents. In all, eight parents were not the boys' natural parents.*

**Table 3. Hypothesis testing through difference of means, by data not grouped for criterion scores,[1] by family classification**

| Statistics | Family classification | | | |
|---|---|---|---|---|
| | Supportive | | Nonsupportive | |
| | First[2] evaluation | Second evaluation | First evaluation | Second evaluation |
| $^2X$ | 1,074 | 1,914 | 952 | 1,714 |
| $^2X$ | 38,958 | 125,956 | 31,120 | 102,062 |
| $\overline{X}$ | 35.8 | [3] 63.8 | 31.7 | 57.1 |
| S.D. | 4.20 | 11.50 | 5.60 | 11.90 |
| [4] t | 3.06 | | 2.22 | |
| Significance | .01 | | .025 | |

[1] *The criterion was "progress" in rehabilitation, as measured by the Youth Behavior Evaluation Form.* [2] *The first evaluation was made 3 months after admission to Shirley; the second, after the boy had been at Shirley for 6 months or more.* [3] *The t value had to exceed 2.00 to be significant at the .025 level in a one-tailed test of significance (McNemar, table E, p. 430).* [4] *The difference of means test was between the boys from the supportive families at the time of the second evaluation (63.8) and the boys from the nonsupportive families on the second evaluation (57.1). Though the difference of means test between the two at the time of the first evaluation (35.8 as opposed to 31.7) was statistically significant, its actual significance was questionable because of the inability to establish an earlier base line.*

ive homes were higher on "progress" scores and frequency of attaining top scores. Apparently, effective early childhood training and the continuing interaction of a supportive family contributed to the boy's progress in rehabilitation.

## Implications

These findings have broad implications for the family, the school, and rehabilitation.

**The family.** If, as the study indicates, a boy's progress in rehabilitation while in an institution is significantly related to his family background, persons trying to prevent delinquency and crime cannot ignore family interaction as a whole. Furthermore, this study shows that some delinquent boys do come from supportive families—families that are integrated and in which the parents care about their children's future. Such parents must be assisted in their efforts to understand delinquent behavior.

**The school.** The delinquent boys in the study were 2 years behind their normal grades, though they were of normal intelligence. The meaning for the school is clear. The public school, geared toward the normal, conforming child pays little attention to the child who is not performing well academically and is overtly aggressive. The schools must provide special instructional programs for such children. The identification of problems by individual testing and interviewing, early and effective counseling, and helping at a time of crisis might prevent the problem from becoming increasingly serious.

Awareness of family dynamics and their effect on learning problems should be a vital part of the training of administrators, teachers, and counselors. Adolescent behavior, deviant or normal, cannot be comprehended without appreciation of the family's role. The interrelationship between education and delinquency must be recognized and studied.

**Rehabilitation.** Rehabilitation and correctional agencies must learn to see the family as a resource for combating juvenile delinquency. When the home is found to be supportive, the delinquent should probably be served by community operations rather than institutionalized.

Delinquent young people with the best potential for rehabilitation should be identified. Were the family the focus of rehabilitation in the case of such young people, improper handling of the problems of adolescents could be reduced. Early recognition of conflicts between young people, family, and society should be met with comprehensive therapeutic acts that include the entire family. Treatment within the family milieu offers more promise of success than institutionalization. Not only the delinquent young person himself but also society will benefit when he is allowed to remain a part of the community's life, as the barriers of rejection are destroyed.

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[1] *Lois Hoffman and Ronald Lippit, "The Measurement of Family Life Variables," in Paul Mussen, ed.,* Handbook of Research Methods in Child Development *(New York: John Wiley and Sons, 1960), Ch. 22.*

[2] *Robert K. Merton and Robert A. Nisbet,* Contemporary Social Problems *(New York: Harcourt, Brace and World, Inc., 1961).*

[3] *Robert Andry,* Delinquency and Parental Pathology *(London: Methuen and Company, Ltd., 1960).*

[4] *Theodore Lidz, Stephen Fleck, and Alice R. Cornelison,* Schizophrenia and the Family *(New York: International Universities Press, Inc., 1965).*

[5] *Francis J. Kelley, "The Delinquent Child: Whose Responsibility?"* Federal Probation, *Dec. 1961, pp. 24-29.*

[6] *Donald H. Stott, "Family Situations Conducive to Behavior Disturbance in Delinquents,"* Social Work, *Feb. 1965.*

[7] *Everett L. Shostrum,* Personality Orientation Inventory Manual *(San Diego: Educational and Industrial Testing Service, 1966).*

[8] *M. Harriet Allen, "Family Dynamics in the Rehabilitation of Delinquent Male Youths," unpublished doctoral dissertation, Boston University, 1969.*

[9] *Donald K. Pumroy, "A New Approach to Treating Parent-Child Problems," report of research grant, NIH (MH 10029-01) (College Park: University of Maryland, 1964).*

[10] *P. Morse Manson and Arthur Lerner,* The Marriage Adjustment Manual *(Beverly Hills: Western Psychological Service, 1962).*

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# The Health Status of AFDC-U Fathers in Santa Clara County

THE PRINCIPAL DIRECTION of services to recipients of aid to families with dependent children-unemployed parent segment (AFDC-U) is toward achieving employment, either through direct job referrals or various training programs designed to improve skill, thus putting a person at more advantage in the competitive labor market. These services are given, for the most part, on the assumption that a man is either ready for the labor market and only lacks a suitable job or is ready to be trained in a marketable skill.

Since 1962, when the Social Security Act was amended to add "unemployment of a parent" to the list of deprivations making a person eligible for aid to families with dependent children (AFDC), many studies have examined the AFDC-U caseload and the characteristics of AFDC-U parents. Most have found that time on aid is not so brief and seasonal as had been assumed and that AFDC-U parents are more dependent and less employable than supposed.

The results of a study conducted last fall by the Santa Clara County (Calif.) Department of Social Services suggest that poor health is one reason why many AFDC-U parents are not employable. It was conducted after a reading of AFDC-U cases indicated that 22 percent of the parents had health problems severe enough to raise questions about the feasibility of employment planning for them, though less than a third of the case records mentioned health as an aspect of employability. There was reason to believe that health as it affected employability was being overlooked in serving AFDC-U parents and that records were silent about health and health problems.

This issue raised two considerations: there could be a number of AFDC recipients classified as *unemployed* who should be reclassified as *incapacitated*; and, if so, health status should be an important aspect in employment planning and should be explored and reported on in all AFDC-U cases.

## Hypothesis and methodology

On the basis of these considerations, it was hypothesized that the AFDC-U caseload contains a sizable proportion of parents whose unrecognized physical problems limited employability in their customary work. It was not, of course, assumed that health problems alone were responsible for what seemed to be prolonged time on aid, but that, probably, a significant number of cases were the result of hidden health problems. The hypothesis further suggested that health and age have a significant relationship, as do length of time on aid and a health problem.

To conduct the study, a sample of 100 AFDC-U families was randomly selected from the August 1, 1969,

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**Correction**

On page 24 of the May-June 1970 issue ("Demonstration Projects in Public Assistance: Fiscal Year 1969"), the first entry after North Carolina should have read as follows:

**Demonstration in Communication Organization:** To encourage and enable public welfare agencies in 25 counties, mostly rural, to participate in and provide leadership for community planning of new and extended social services, particularly in behalf of low-income families.

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caseload in the County Welfare Department. The shrinkage from the original sample was later supplemented with new applicants and referrals by Department social workers. The fathers in the families selected were informed that, as part of their preemployment planning evaluation, they would be requested to undergo a comprehensive physical examination. In all, 93 men completed the project.

A preexamination group meeting was held to acquaint the men with the purpose of the examination and to obtain their cooperation. Because some of the men were Spanish speaking, a vocational services worker fluent in Spanish took part in the meeting. The men were taken individually to a private practitioner, and all tests and examinations were completed during a single visit.

The examining physician was asked to classify each man according to the following code:

0 - No impairments
1 - No significant impairment in ability to do customary work
2 - Impairment severe enough to affect or limit ability to do customary work
3 - Disabling impairment

The age and aid histories of each participant were determined by reading the case records. The data were subjected to the usual statistical testing to determine the significance of the relationships observed between health, age, and aid history.

## Findings

The findings of the study indicate that many of the men did have severe health problems:

- About 20 percent had medical impairments that were either completely disabling (4 percent) or severe enough (16 percent) to affect or limit ability to do their customary work.
- About 59 percent had health problems, though not severe enough to affect their working ability. However, 50 percent of this group had medical problems requiring further medical care or evaluation (which might have found some of them partly disabled).
- Only about 20 percent had no significant health problems.

Table 1 illustrates the findings.

**Table 1. Percent of sample with health problem**

| Health code | Number | Percent |
|---|---|---|
| 0 | 19 | 20 |
| 1 | 55 | 59 |
| 2 | 15 | 16 |
| 3 | 4 | 4 |
| Total | 93 | [1] 99 |

[1] *Does not add to 100 percent due to rounding errors.*

**Table 2. Total time on aid, by health status**

| Health code | Average total number of months on aid | |
|---|---|---|
| | AFDC–FG and AFDC–U[1] | AFDC–U only[1] |
| 0 | 24.8 | 16.3 |
| 1 | 46.9 | 24.1 |
| 2 | 53.8 | 25.5 |
| 3 | 42.8 | 19.0 |

[1] *Relationships between code 0 and others are statistically significant. Fischer's "t" test p= < .05.*

**Table 3. Health code, by average time on aid since last case opening**

| Health code | Average number of months[1] on aid |
|---|---|
| 0 | 15.7 |
| 1 | 25.3 |
| 2 | 35.5 |
| 3 | 58.3 |

[1] *Relationships between code 0 and others are statistically significant. Fischer's "t" test p=<.01.*

**Table 4. Health status, by age**

| Health code | Average age |
|---|---|
| 0 | [1] 30 |
| 1 | 42 |
| 2 | 44 |
| 3 | 38 |

[1] *Relationships between code 0 and others are statistically significant. Fischer "t" test p= < .01.*

The data also indicate that there was a statistically significant relationship between length of time on AFDC and whether the man had a health problem. Table 2 shows the health code and the average time on aid for each health code, for both total AFDC time and for time as a U case. An analysis of the data by comparing health status and average time on aid since last case opening found a statistically significant relationship between the two. The healthy men had been on aid for a significantly shorter period of time than those with health problems. Table 3 shows the average time on aid since the last case opening for each health code. It also shows the significance of the findings between codes.

There was also a statistically significant relationship between age and health status. See table 4. As might be expected, the younger men were in better health. The average age of the man in the total sample was 40; the average age of those with no significant medical problems was 30. The average age of those with medical problems not related to their ability to work was 42; of those with health problems severely limiting their ability to do their customary work, 44. The four men who were totally disabled represent a wide variation in ages (26 to 47), but so small a sample rules out valid generalizations.

By the Employment Health Standards of the Santa Clara County Personnel Department, almost half (43 percent) of the men could not

have qualified for employment with the County. Table 5 shows the distribution of impairments among the 93 men studied.

**Table 5. Distribution of the impairments discovered among the 93 men examined[1]**

| Degree of impairment | Frequency |
|---|---|
| **Completely disabled–code 3** | |
| Severe liver disease | 3 |
| Diabetes | 1 |
| Herniated lumbar disc | 1 |
| Hemolytic anemia[2] | 1 |
| Probable schizophrenia | 1 |
| Right inguinal hernia | 1 |
| **Severe enough to affect or limit ability to do customary work–code 2** | |
| Hypertension | 4 |
| Herniated lumbar disc, post laminectomy | 4 |
| Diabetes | 3 |
| Alcoholism | 2 |
| Obstructive pulmonary disease | 2 |
| Coronary heart disease | 2 |
| Retinal detachment | 1 |
| Arthritis | 1 |
| Traumatic foot amputation, residual disability | 1 |
| Hearing loss | 1 |
| Possible schizophrenia | 1 |
| Bronchial asthma | 1 |
| Bilateral club foot deformity | 1 |
| **Others with need for further medical care or evaluation with some degree of urgency–code 1** | |
| Mild hypertension | 7 |
| Abnormal chest X-ray | 5 |
| Obstructive pulmonary disease | 4 |
| Diabetes | 4 |
| Inactive syphilis | 3 |
| Chronic bronchitis | 3 |
| Inguinal hernia | 3 |
| Gastric ulcer | 3 |
| Healing rib fractures | 2 |
| Cirrhosis–chronic alcoholism | 2 |
| Extreme obesity | 2 |
| Possible diabetes | 2 |
| Chronic brain syndrome | 1 |
| Right bundle branch block | 1 |
| Chronic low back pain | 1 |
| Abnormal serology | 1 |
| Possible chronic kidney disease | 1 |
| Probable liver disease | 1 |
| Chronic gall bladder disease | 1 |
| Secondary heart and vascular disease | 1 |
| Diaphragmatic hernia | 1 |
| Gout | 1 |
| **No more follow up needed–code 1** | 27 |
| **No abnormal findings–code 0** | 19 |

[1] *Some men had more than one type of health impairment.* [2] *This man died 1 month later, although the disease had been unrecognized previously.*

## Conclusions and recommendations

On the basis of the data, it appears that the AFDC-U caseload count in Santa Clara County at the time of the study could have been inflated by as much as 20 percent because of the inclusion of families in which the unemployed father was medically unfit to follow his usual occupation. As these men were not employable or ready for suitable training plans without further evaluation of their health and physical condition as related to employability, they should have been classified, at least temporarily, as *incapacitated.*

In discussions among the staff members of the project, several aspects relating to classification of cases as U or as incapacitated became apparent:

- The budget allowance for the U family is $6 more a month than for an "incapacitated" family.
- Unemployed men (AFDC-U fathers) receive preferential consideration and are given priority in vocational services over incapacitated men.
- Many men are afraid, for one reason or another, to see a physician, maintaining that they are in good health, even though the social worker may have good reasons for strong suspicions to the contrary. In such a case, the worker has no basis for assigning the man to incapacitated status without supportive medical evaluation.

These findings suggest that social workers should be especially alert to indications of health impairments in U cases, especially those where the man is past 40, has been unemployed for some time, or whose work history shows numerous short-term work periods in jobs that do not generally turn over fast.

IN SANTA CLARA COUNTY several AFDC bureaus have begun to give workers additional training in recognition of symptoms that suggest the need for referral to a physician. Because medical care programs are available in the County, it seems that one of the most important services a worker can render is to help AFDC recipients use the programs in early recognition and treatment of health problems.

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## Public Assistance in January and February 1970

ABOUT 11.5 MILLION PERSONS received money payments in February 1970, or about 174,000 more than in January 1970, under the five public assistance programs. All programs except one had increases. As in each of the past 19 months, the program of aid to families with dependent children (AFDC) accounted for most of the national increase. The number of children and adults receiving AFDC rose from 7,480,000 to 7,645,000. The number of persons receiving aid to the permanently and totally disabled (APTD) rose by 7,000 to 818,000. About 2,065,000 persons received old-age assistance (OAA), and about 915,000 general assistance (GA) in February, a rise of 1,000 in each program over January. The number of persons receiving aid to the blind (AB)—80,300—was 100 smaller in February than in January.

Fewer needy families with children received emergency assistance in February than in January: 6,400, as compared with 8,800. Payments to intermediate care facilities were made for about 112,000 persons, a rise of 2,000.

For the five programs, money payments were $634.9 million, up by $8.4 million from January. Total expenditures for maintenance assistance came to $662.3 million—an increase of $8 million. Among the programs providing payments, the largest increase ($7.5 million) occurred in AFDC. Payments were lower for emergency assistance, by $292,000, and to intermediate care facilities, by $86,000.

The average money payment per recipient was virtually the same in the 2 months in each program (GA

**Changes in public assistance: Recipients, payments, and money payments per recipient, January and February 1970 and February 1969**

| Program | February 1970 | January 1970 | February 1969 |
|---|---|---|---|
| **Recipients of money payments** | | | |
| Old-age assistance | 2,065,000 | 2,064,000 | 2,025,000 |
| Aid to the blind | 80,300 | 80,400 | 80,300 |
| Aid to the permanently and totally disabled | 818,000 | 811,000 | 718,000 |
| Aid to families with dependent children | | | |
| Families | 1,966,000 | 1,920,000 | 1,592,000 |
| Recipients | 7,645,000 | 7,480,000 | 6,384,000 |
| Children | 5,643,000 | 5,531,000 | 4,749,000 |
| General assistance | | | |
| Cases | 445,000 | 442,000 | 402,000 |
| Recipients | 915,000 | 914,000 | 828,000 |
| **Assistance payments (in 000's)** | | | |
| Total | $1,086,245 | $1,062,441 | $916,217 |
| Money payments, total | 634,942 | 626,566 | 519,870 |
| Old-age assistance | 155,194 | 154,800 | 141,990 |
| Aid to the blind | 8,051 | 8,050 | 7,478 |
| Aid to the permanently and totally disabled | 74,524 | 74,162 | 60,533 |
| Aid to families with dependent children | 350,547 | 343,038 | 272,556 |
| General assistance | 46,626 | 46,516 | 37,313 |
| Medical assistance, total | 423,941 | 408,135 | 383,869 |
| Federally aided | 417,779 | 402,548 | 378,095 |
| General assistance | 6,162 | 5,587 | 5,774 |
| Emergency assistance | 701 | 993 | — |
| Payments to intermediate care facilities | 26,661 | 26,747 | 12,478 |
| **Money payments per recipient** | | | |
| Old-age assistance | $75.15 | $75.00 | $70.10 |
| Aid to the blind | 100.30 | 100.15 | 93.15 |
| Aid to the permanently and totally disabled | 91.05 | 91.45 | 84.30 |
| Aid to families with dependent children | | | |
| Average per family | 178.35 | 178.70 | 171.25 |
| Average per recipient | 45.85 | 45.85 | 42.70 |
| General assistance | | | |
| Average per case | 104.55 | 105.25 | 92.85 |
| Average per recipient | 51.75 | 50.90 | 45.05 |

rose by about $1). February averages per recipient were $100 in AB, $91 in APTD, $75 in OAA, $46 in AFDC, and $52 in GA.

Expenditures for medical assistance were $423.9 million in February, $15.8 million more than in January. (Beginning in January 1970, Federal financial participation in expenditures for payments to medical vendors is limited to payments made under Title XIX Medicaid programs.) During the first 8 months of fiscal year 1970 (July 1, 1969-June 30, 1970), payments amounting to $3.2 billion were made from public assistance funds (including GA) for medical assistance. In the same 8 months of the preceding fiscal year, the corresponding total was $2.9 billion. Most of the payments—95 percent—were made to medical vendors; the rest were premium payments or per capita payments into the Social Security Administration system, into agency pooled funds, and to health insurance agencies.

The table shows changes from January to February 1970 and statistics for February 1969. The number of recipients in all programs except AB rose over the year, as did expenditures for all programs.

Material in this article is based on NCSS Report A-2 (1/70) and NCSS Report A-2 (2/70). Copies of these reports may be obtained by writing the National Center for Social Statistics, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

# New Publications

## U.S. Government

*Publications for which prices are listed may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (25 percent discount on orders of 100 or more). Payment must accompany order. Single copies of unpriced publications are available from the issuing agency.*

Social and Rehabilitation Service

**Door to opportunity—title V, Economic Opportunity Act: a summary report of the Work Experience and Training Program, 1964-1969,** by Jeanette Stats. 1970, 64 pp. Discusses the background, effects, and implications of the title V program. Community Services Administration publication SRS-CSA-127-1970.

## Non-Government

*Send inquiries and orders to the publisher or issuing agency.*

**Aids to independent living: self-help for the handicapped,** by Edward W. Lowman and Judith L. Klinger. McGraw-Hill Book Co., 330 W. 42d St., New York, N.Y. 10036. 1969, 796 pp., $39. Catalogs devices to help the handicapped take care of themselves and presents a list of organizations, films, and sources of equipment.

**Behavior in new environments: adaptation of migrant populations,** Eugene B. Brody, ed. Sage Publications, 275 S. Beverly Dr., Beverly Hills, Calif. 90212. 1969, 479 pp., $9.95. Presents papers from a conference on the social, psychological, and psychiatric problems of people in transition such as Mexican-Americans, Negroes, and Alaskan natives.

**Black ghetto family in therapy: a laboratory experience,** by Clifford J. Sager and others. Grove Press, 80 University Pl., New York, N.Y. 10003. 1970, 245 pp., $6.50. Describes a role playing session in which Negro social workers act as members of a troubled family interviewed by white therapists.

**Brookings papers on economic activity: I,** Arthur M. Okun and George L. Perry, eds. Brookings Institution, 1775 Massachusetts Ave., N.W., Washington, D.C. 20036. 1970, 162 pp., $2.50. Contains the first of a series of papers from the Brookings Panel on Economic Activity that seeks to analyze the issues facing decision makers in the public and private sectors.

**The challenge of world poverty: a world anti-poverty program in outline,** by Gunnar Myrdal. Pantheon Books, 437 Madison Ave., New York, N.Y. 10022. 1970, 518 pp., $8.95. Summarizes the basic research and conclusions of his previously published **Asian drama** and outlines proposals for radical reform.

**Children in trouble,** by Howard James. David McKay Co., 750 3d Ave., New York, N.Y. 10017. 1970, 340 pp., $6.95. Describes the "unbelievably deplorable conditions" for children in trouble in the United States and calls for action through legislation and education.

**Coming up black: patterns of ghetto socialization,** by David A. Schulz. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1969, 209 pp., $5.95. Tries to "overcome the middle-class myopia often experienced in looking at the ghetto" by studying the growing-up process in a midwestern city ghetto.

**The common base of social work practice,** by Harriett M. Bartlett. National Association of Social Workers, 2 Park Ave., New York, N.Y. 10016. 1970, 224 pp., $4. Discusses the ways social workers think about their practice.

**The community activist's handbook,** by John Huenfeld. Beacon Press, Inc., 25 Beacon St., Boston, Mass. 02108. 1970, 160 pp., $6. Tells how to organize, finance, and publicize community campaigns.

**Data bases, computers, and the social sciences,** Ralph L. Bisco, ed. Wiley-Interscience, John W. Wiley & Sons, 605 3d Ave., New York, N.Y. 10016. 1970, 291 pp., $12.50. Includes papers on privacy, data structures, problems and solutions, and government as the major producer, user, and archivist of social science data.

**The diary of A.N.: the story of the house on West 104th Street,** by Julius Horwitz. Coward McCann, Inc., 200 Madison Ave., New York, N.Y. 10016. 1970, 220 pp. $5.95. Describes life on welfare as told in the diary of a 15-year old black girl. (Fiction.)

**The enemies of the poor,** by James J. Graham. Random House, 30 W. 60th St., New York, N.Y. 10023. 1970, 308 pp., $7.95. ". . .shows how the churches, unions, welfare system, and legal profession are failing the poor."

**Family group casework: a casework approach to family therapy,** Donald R. Bardill and Francis J. Ryan. Rev. ed. Catholic University of America Press, 620 Michigan Ave., N.E., Washington, D.C. 20017. 1969, 69 pp., $1.75. Discusses theory, method, and the role of the caseworker.

**Ghetto crisis: riots or reconciliation,** by Henry Etzkowitz and Gerald M. Schaflander. Little, Brown and Co., 34 Beacon St., Boston, Mass. 02106. 1969, 212 pp., $5.95. Describes a pilot community cooperative center in the Bedford-Stuyvesant section of Brooklyn that tried to protect ghetto children from neglect and violence through a low-cost, 12-hour a day, child-care center.

**Group work in the institution: a modern challenge,** by Gisela Konopka. Rev. ed. Association Press, 291 Broadway, New York, N.Y. 10007. 1970, 304 pp., $7.95. Presents material for lay and professional workers in institutions for children, the handicapped, delinquents, unmarried mothers, the elderly, and prisoners.

**Illegitimacy: changing services for changing times.** National Council on Illegitimacy, 44 E. 23rd St., New York, N.Y. 10010. 1970, 98 pp., $3.25. Contains seven papers presented at the 1969 National Conference on Social Welfare; the research for four of the studies was supported by the Children's Bureau and the Social and Rehabilitation Service.

**Methodology in evaluating the quality of medical care: an annotated selected bibliography, 1955-1968,** by Isidore Altman and others. University of Pittsburgh Press, 3309 Cathedral of Learning, Pittsburgh, Pa. 15213. 1969, 214 pp., $3.95. Discusses standards and recommendations, elements of performance, effects of care, and general approaches.

**Nonprofessionals in the human services,** Charles Grosser and others, eds. Jossey-Bass Publishers, 615 Montgomery St., San Francisco, Calif. 94111. 1969, 263 pp., $8.50. Presents papers from a joint meeting of the American Psychological Association and the National Association of Social Workers on the training of nonprofessional workers, manpower development programs, Congressional action, and problems of professionalism.

**The omni-American: new perspectives on black experience and American culture,** by Albert Murray. Outerbridge and Dienstfrey, 200 W. 72d St., New York, N.Y. 10023. 1970, 227 pp., $6.95. Contains essays, commentaries, and reviews refuting current beliefs and conclusions about certain phases of Negro life in the United States.

**Parents and the day care center,** by Thelma Adair and Esther Eckstein. Federation of Protestant Welfare Agencies, 201 Park Ave. South, New York, N.Y. 10003. 1969, 36 pp., $1.50. Suggests how to start, maintain, and expand parent-center participation.

**Physical disability and human behavior,** by James W. McDaniel. Pergamon Press, Fairview Park, Maxwell House, Elmsford, N.Y. 10523. 1969, 231 pp., $7.95. Describes recent methods of treating the psychological effects of chronic illness and physical disability.

**The poor ye need not have with you: lessons from the War on Poverty,** by Robert A. Levine. M.I.T. Press, 77 Massachusetts Ave., Cambridge, Mass. 02139. 1970, 262 pp., $7.95. Includes such chapters as "A biased history of the War on Poverty"; "An equally biased evaluation of the War on Poverty"; and "Future directions."

**Poverty, participation, protest, power, and black Americans: a selected bibliography for use in social work education,** Charlotte Dunmore, comp. Council on Social Work Education, 345 E. 46th St., New York, N.Y. 10017. 1970, 67 pp., $3.

**Poverty warriors: the human experience of planned social intervention,** by Louis A. Zurcher, Jr. University of Texas Press (for the Hogg Foundation for Mental Health), Austin, Tex. 78712. 1970, 442 pp., $10. ". . .analyzes and interprets experiences of men and women, poor and not poor, who were warriors in the OEO poverty program in Topeka, Kansas."

**The price of dependency: civil liberties in the welfare state,** by Robert M. O'Neil. E. P. Dutton and Co., 201 Park Ave. South, New York, N.Y. 10003. 1970, 351 pp., $8.95. Examines the conditions attached to benefits from government, scholarships, welfare, and housing and their effect on individual rights and freedoms.

**Public expenditures and policy analysis,** Robert H. Haveman and Julius Margolis, eds. Markham Publishing Co., 863 N. Dearborn, Chicago, Ill. 60610. 1970, 596 pp., $9. Presents essays, many from the publications of the Joint Economic Committee of the Congress, including "The planning, programming, and budgeting system in the Department of Health, Education, and Welfare," by Alice M. Rivlin; "Problems of resource allocation in health,"

by Robert N. Grosse; and "Education program analysis at HEW," by John E. Brandl.

**The recovery of confidence,** by John W. Gardner. W. W. Norton and Co., 55 5th Ave., New York, N.Y. 10003. 1970, 189 pp., $5. Contains essays by a former Secretary of Health, Education, and Welfare on institutions, dissent, society, the individual and the community, leadership, and urban problems.

**Rural poverty and the urban crisis: a strategy for regional development,** by Niles M. Hansen. Indiana University Press, 10th and Morton Sts., Bloomington, Indiana 47401. 1970, 352 pp., $12.50. Offers a policy for dealing with the problems of Appalachia, the South, Indians, and Mexican-Americans.

**Social and economic information for urban planning,** by Doris B. Holleb. Center for Urban Studies of the University of Chicago, 5848 S. University Ave., Chicago, Ill. 60637. 1969, 2 vols., $2 each. Makes recommendations for obtaining, selecting, and using planning information and presents a directory of sources on health, welfare, education, housing, transportation, and other urban problems.

**Stations of the lost: the treatment of Skid Row alcoholics,** by Jacqueline P. Wiseman. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1970, 346 pp.. $8.95. Describes life on the "rehab loop" as seen by both the alcoholics and the agents of social control.

**Toward an industrial gerontology: an introduction to a new field of applied research and service,** Harold L. Sheppard, ed. Schenkman Publishing Co., 1 Story Street, Cambridge, Mass. 02138. 1970, 165 pp., $7.95. Contains papers on the employment and employment problems of the elderly, including training and retraining, age discrimination, new careers, motivation, and other factors.

**Transportation needs of the poor: a case study of New York City,** by Oscar A. Ornati. Praeger, Inc., 111 4th Ave., New York, N.Y. 10003. 1969, 127 pp., $10. Focuses on New York City but also discusses transportation conditions in other urban areas.

**Uprooted children: the early life of migrant farm workers,** by Robert Coles. University of Pittsburgh Press, 3309 Cathedral of Learning, Pittsburgh, Pa. 15213. 1970, 142 pp., $3.95. (Horace Mann lecture, 1969.) Presents a psychiatric study of migrant farm children—Negro, white, and Mexican-American—on the eastern seaboard and depicts the deplorable conditions in which they grow up.

**Urban processes as viewed by the social sciences.** Urban Institute, 2100 M St., N.W., Washington, D.C. 20037. 1969, 79 pp., $1.95. Contains papers for a symposium organized by the Urban Institute for the National Academy of Sciences concerning the institutions that distribute wealth and power.

**Where medicine fails,** Anselm L. Strauss, ed. Aldine Publishing Co., 320 W. Adams St., Chicago, Ill. 60606. 1970, 171 pp., $5.95. (Trans-Action book TA-4.) Presents the views of social scientists on the psychological, social, economic, and organizational results of chronic illness and points out the imbalance in health care distribution.

**The worker grows old,** by George S. Rosenberg. Jossey-Bass Publishers, 615 Montgomery St., San Francisco, Calif. 94111. 1970, 206 pp., $8.50. Reports on a study of the social isolation of low income white working-class men in Philadelphia.



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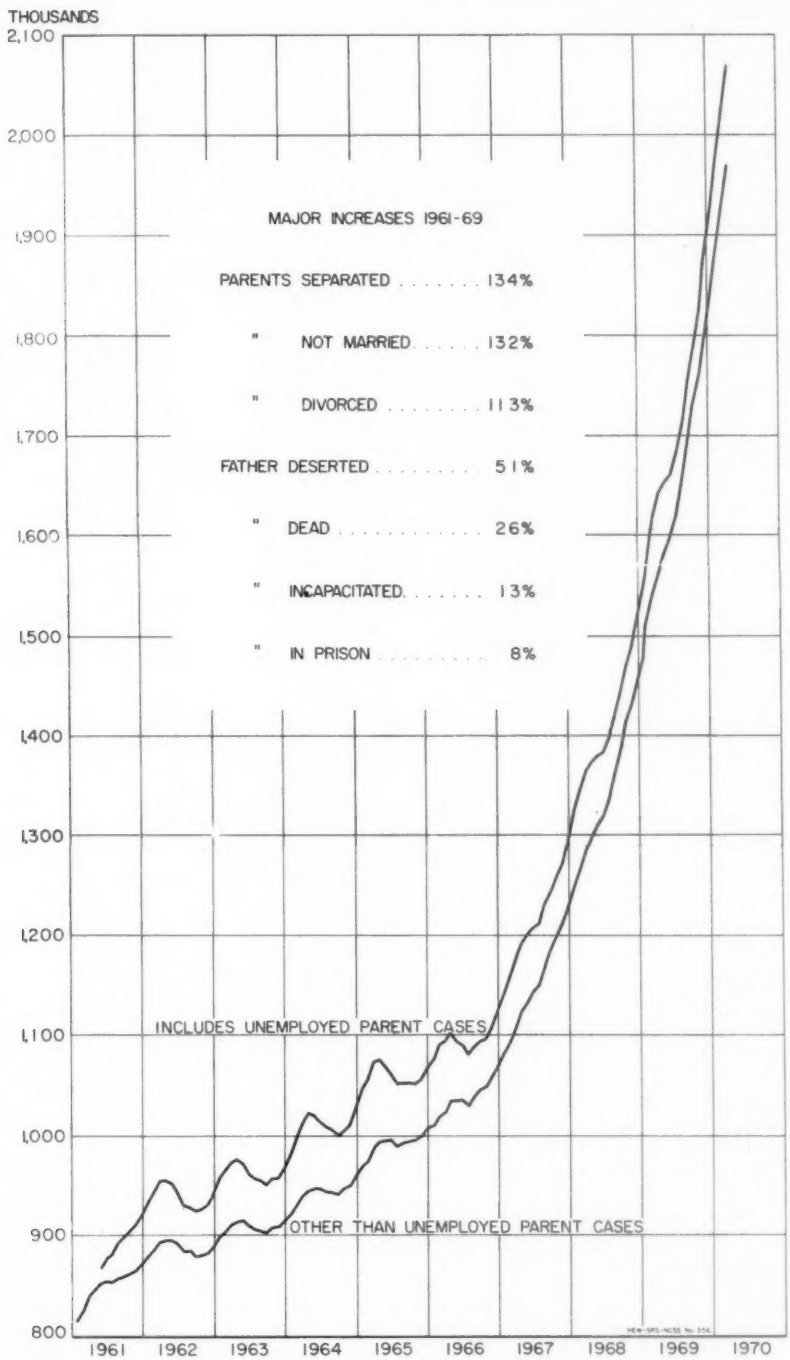
## TREND IN AFDC CASES, 1961 TO DATE



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